FERMI NATIONAL ACCELERATOR LABORATORY
GROUP EMPLOYEE BENEFITS
OPEN ENROLLMENT FORM

CHECK ONE: ☐ ACTIVE ☐ NO PAY ☐ COBRA ☐ LTD				CHECK ONE: ☐ MONTHLY PAID ☐ WEEKLY PAID			
CHANGE:	FROM:	MED. TO:	MED.	CHANGE:	FROM:	DENT. TO:	DENT.

ID_____ LAST NAME_____ FIRST NAME_____ M.I._____.

ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____.

DATE OF BIRTH_____ SOCIAL SECURITY NUMBER_____.

HOME PHONE NUMBER_____ SPOUSE'S WORK PHONE NUMBER_____.

MEDICAL COVERAGE **LEVEL OF COVERAGE**

Check One ⇓ OFFICE USE ONLY ⇓

☐ CIGNA PPO (0343767) Pol.Code: 07 Clm.Div:_____ Ben.Code:_____
☐ CIGNA POS (an HMO) Pol.Code: 09 Clm.Div:_____ Ben.Code:_____
☐ HMO ILLINOIS Clm.Div: _____
☐ WAIVE COVERAGE Coverage Change

☐ EMPLOYEE ONLY
☐ FAMILY

Effective Date (HMO IL only):_____

I waive coverage because I and/or my dependents have medical coverage under another medical plan. I understand by refusing coverage that I can subsequently enroll only during an open enrollment period or when I qualify under special enrollment requirements under the Health Insurance Portability and Accountability Act of 1999.

OFFICE USE ONLY
Effective Date

Family

LIST ELIGILBE DEPENDENTS YOU WANT COVERED UNDER YOUR MEDICAL PLAN, OR WRITE "DELETE" NEXT TO THOSE YOU WISH TO DROP

Name: Last / First / M.I.	Social Security Number	Sex	DOB	HMO IL and CIGNA POS select a Primary Care Physician	MD or Group ID# POS and HMO IL	New Patient Y/N
SELF:						
SP:						
C1:						
C2:						
C3:						

DENTAL COVERAGE **LEVEL OF COVERAGE**

Check One ⇓ OFFICE USE ONLY ⇓

☐ CIGNA DENTAL PPO Pol.Code: 10 Clm.Div:_____ Ben.Code: N/A
☐ CIGNA DENTAL HEALTH (HMO) Pol.Code: 06 Clm.Div:_____ Ben.Code: N/A
☐ WAIVE COVERAGE

☐ EMPLOYEE ONLY
☐ FAMILY

If you are waiving dental coverage for yourself or your dependents (including your spouse), you can only subsequently enroll in the Cigna Dental PPO plan only upon presenting satisfactory evidence of insurability approved by Connecticut General or you can enroll in either dental plan at the next Open Enrollment.

OFFICE USE ONLY
Effective Date

Employee

Family

LIST ELIGIBLE DEPENDENTS YOU WANT COVERED UNDER YOUR DENTAL PLAN, OR WRITE "DELETE" NEXT TO THOSE YOU WISH TO DROP

Name: Last / First / M.I.	Social Security Number	Sex	DOB	CIGNA DENTAL HEALTH (HMO) PLEASE ENTER 6 DIGIT DENTAL OFFICE # BELOW
SELF:				
SP:				
C1:				
C2:				
C3:				

(OVER)

EMPLOYEE NOTIFICATION

Single employees are eligible to select only one health plan. Married employees are eligible to select only one health plan for themselves and their dependents. (If husband and wife are both employees of URA/Fermilab, they cannot be covered under more than one health plan. Each can be in a separate plan, but each cannot be covered under two plans. Their eligible children are covered as dependents of only one parent.)

EMPLOYEE AUTHORIZATION AND CERTIFICATION

I authorize URA/Fermilab to deduct from my paycheck the appropriate contributions, if any, to the employee benefit plans that I have elected. Contributions for medical and dental coverage will be done on a before tax basis unless the employee signs a waiver form. I hereby certify that the information that I have provided on this form is true and correct to the best of my knowledge.

_____ _____

_____ _____

EMPLOYEE SIGNATURE DATE BENEFITS OFFICE DATE